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IN THE

Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC., and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES AND DEPENDENTS OF EARTH SYSTEMS, INC.,

Petitioners,

v.

JANETTE KNUDSON and ERIC KNUDSON,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF MARYLAND HMO SUBROGATION PLAINTIFFS FOR LEAVE TO FILE AN *AMICI CURIAE* BRIEF AND BRIEF IN SUPPORT OF RESPONDENTS

Arthur H. Bryant
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
One Kaiser Plaza
Suite 275
Oakland, CA 94612
(510) 622-8150

F. Paul Bland, Jr.
(Counsel of Record)
Leslie Brueckner
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
1717 Massachusetts Avenue, N.W.
Suite 800
Washington, D.C. 20036
(202) 797-8600

Attorneys for *Amici Curiae*
Maryland HMO Subrogation Plaintiffs

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Victor Riemer, Stephen and Janet Marx, Douglas Harvey, Shade Popoola, Sabriyaha Singh, Angie Dixon, and Phyllis Balthrop (collectively the "Maryland HMO Subrogation Plaintiffs") respectfully move this Court, pursuant to Rule 37.4, for leave to file a brief as *amici curiae* in support of respondents Janette and Eric Knudson. Consent to file this brief was granted by respondents but withheld by petitioners.

The Maryland HMO Subrogation Plaintiffs are each plaintiffs in cases filed in Maryland state courts alleging that HMOs illegally recovered funds from them under claims of

subrogation.[1] Their argument that HMOs were prohibited from engaging in subrogation under Maryland law was accepted in full by Maryland's highest court in *Riemer v. Columbia Medical Plan*, 747 A.2d 677 (2000).[2] The Maryland HMO Subrogation Plaintiffs

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[1] Mr. Harvey is the plaintiff in the case of *Harvey v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.* (Cir. Ct. Mont. Cty. Civil No. 211349); Mr. Riemer and the Marxes are the named plaintiffs in the putative class action *Riemer v. Columbia Medical Plan* (Cir. Ct. How. Cty. Civil No. 96 (A31528) and 4th Cir. No. 98-1136; Ms. Popoola is the named plaintiff in the putative class action *Popoola v. M.D. Individual Practice Ass'n* (Cir. Ct. Mty. Cty. Civil No. 21148); Ms. Dixon is the named plaintiff in the putative class action *Dixon v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.* (Cir. Ct. Mty. Cty. Civil No. 211350v); Ms. Singh is the named plaintiff in the putative class action *Singh v. Prudential Health Care Plan, Inc.* (Cir. Ct. Mty. Cty. Civ. No. 211346v); and Ms. Balthrop is the named plaintiff in the putative class action *Balthrop v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.* (Cir. Cty. Mty. Cty. Civil No. 211347). Some of these cases have been removed to federal court and are the subject of motions to remand, or of appeals relating to ERISA preemption.

[2] Shortly after *Riemer* was decided, the Maryland legislature passed legislation permitting HMOs to subrogate, though under the new bill (with one exception) they may only do so to the extent of their actual costs (rather than the claimed fair market value of their services), and they may only do so if they directly adjust their premiums downwards. *See* 2000 Maryland Laws, Chapter 569. While this statute is retroactive for a period of 24½ years, the question of whether the retroactivity provision violates the Maryland and United States Constitutions is before Maryland's highest court in *Harvey v. Kaiser Foundation Health* (continued...)

have a strong interest in seeing that this body of state law is not swept aside.

This case poses the question of whether an ERISA plan may bring an action under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), to enforce a subrogation claim. The Maryland HMO Subrogation Plaintiffs have no interest in (and will not address) most of the statutory arguments related to this question, such as whether a cause of action for restitution is legal or equitable in nature, or whether such a cause of action is comparable to one for the imposition of a constructive trust. Nonetheless, the Maryland HMO Subrogation Plaintiffs have a significant interest in this case because petitioners and several of their *amici* have urged this Court to hold that subrogation is required to prevent the unjust enrichment of insureds.

In making this request, petitioners and some of their *amici* go beyond the question of the proper meaning of Section 1132(a)(3) and ask this Court to hold that ERISA embodies substantive law favoring or even requiring that health insurers be permitted to pursue their insureds for subrogation. If this Court were to embrace this suggestion, it would create a significant new body of federal law in an area long governed by state law, and potentially override the state law relied upon by the Maryland HMO Subrogation Plaintiffs. Such an expansion of federal law would eradicate the substantive judgments of myriad states about the wisdom of permitting subrogation.

While respondents oppose petitioners' arguments on the proper interpretation of Section 1132(a)(3), their case does not involve a state anti-subrogation statute. Respondents, therefore,

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[2] (...continued)
Plan of the Mid-Atlantic States, Inc., No. 121 (Md. September 2000 Term).

have little reason to address the effect that the arguments advanced by petitioners and their *amici* could have on such statutes or on ERISA's relationship to similar substantive state law provisions. The Maryland HMO Subrogation Plaintiffs seek leave to file the enclosed brief to ensure that the Court appreciates the serious flaws in petitioners' and their *amici's* attacks on subrogation and the dangerous extent to which those attacks threaten this Court's past interpretation of ERISA, established state laws, and important principles of federalism.

Respectfully submitted,

F. Paul Bland, Jr. *(Counsel of Record)*
Leslie Brueckner
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
1717 Massachusetts Avenue, N.W.
Suite 800
Washington, D.C. 20036
(202) 797-8600

Arthur H. Bryant
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
One Kaiser Plaza
Suite 275
Oakland, CA 94612
(510) 622-8150

Attorneys for *Amici Curiae*
Maryland HMO Subrogation Plaintiffs

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BRIEF OF *AMICI CURIAE* MARYLAND SUBROGATION PLAINTIFFS

INTEREST OF MARYLAND HMO SUBROGATION PLAINTIFFS[1]

The Maryland Subrogation Plaintiffs are plaintiffs in cases filed in Maryland state court seeking to recoup funds taken from them by Health Maintenance Organizations ("HMOs") under claims of

[1] No counsel for any party authored the brief in whole or in part, and no person or entity other than *amici curiae* made any monetary contribution to its preparation or submission.

subrogation. Maryland's highest court has already held that the HMOs actions violated a Maryland state anti-subrogation law. *Riemer v. Columbia Medical Plan*, 747 A.2d 677 (2000). The petitioners and some of their *amici* here, however, are urging this Court to go beyond the question presented in this case – which does not involve a state anti-subrogation statute – and issue a ruling calling the validity of such statutes into question. We submit this brief both to explain why the Court should reject that suggestion and to expose the dangerous flaws in the attacks on subrogation advanced by petitioners and their *amici*.

SUMMARY OF ARGUMENT

This case poses the question of whether an action under 29 U.S.C. § 1132(a)(3) to enforce a subrogation claim is a legal or equitable action. To resolve this question, petitioners and some of their *amici* have asked this Court to wade into the underlying merits of this controversy and to announce that subrogation by insurers is necessary to avoid the unjust enrichment of insureds. Such a substantive judgment is not necessary to the resolution of this case, and contradicts the substantive judgments of a number of states.

A number of state legislatures and high courts have adopted legislation or common law rules that prohibit medical insurers from pursuing their own insureds for subrogation (or sharply limit the practice). Other state legislatures and high courts have permitted health insurers to engage in subrogation. Thus, notwithstanding the one-sided policy pronouncements in the briefs of petitioners and their *amici*, this is a subject on which state lawmakers and courts can and do reasonably disagree, and there are powerful policy arguments in favor of the proposition that health insurers should be barred from engaging in subrogation.

If this Court were to announce a new rule of substantive law that subrogation is necessary to avoid unjust enrichment, it would raise the possibility that ERISA's enforcement provisions (including Section 1132(a)(3)), would conflict with ERISA's Savings Clause (29 U.S.C. § 1144(b)(2)(A)). For some time, it has been recognized that ERISA does not prevent states from prohibiting (or allowing or otherwise regulating) subrogation by insurers. Indeed, this Court has held that state anti-subrogation statutes are clearly a "regulation of insurance" within the scope of ERISA's Savings Clause, except with respect to self-funded plans, which are themselves excepted from ERISA's Savings Clause. *FMC v. Holliday*, 498 U.S. 52 (1990). As this brief will set forth below, if this Court were to declare that subrogation is necessary to avoid unjust enrichment, the health insurance industry has already signaled its intention to use such a statement to mount an ERISA preemption attack upon state anti-subrogation statutes notwithstanding ERISA's Savings Clause.

The assertion by petitioners and their *amici* that health insurers should be permitted to engage in subrogation because subrogation is good policy is contrary to the considered judgment of many state legislatures and state high courts. It is also wrong. The views of these state authorities are supported by powerful policy arguments and should not be swept aside. Subrogation gives health insurers a windfall by providing them with a second recovery for medical costs for which they have already been paid a premium. Subrogation by health insurers is thus contrary to the long-standing doctrine of the collateral source rule, which has been adopted by the vast majority of states and has been endorsed by this Court since 1854. Subrogation by health insurers also typically denies personal injury claimants a full recovery for their injuries, and has not been shown to have any impact whatsoever on health insurance premiums. Accordingly, this Court should reject the suggestion by petitioners and their *amici* that it go

beyond the issue presented in this case and call into question the validity of state laws banning subrogation.

ARGUMENT

I. CONTRARY TO THE SUGGESTIONS OF PETITIONERS AND THEIR *AMICI*, ERISA DOES NOT REQUIRE THE ENFORCEMENT OF SUBROGATION CLAUSES.

A. PETITIONERS AND THEIR *AMICI* URGE THIS COURT TO ATTACK THE SUBSTANTIVE JUDGMENT UNDERLYING STATE ANTI-SUBROGATION STATUTES.

Many states have statutes or common law rules prohibiting or sharply limiting subrogation by some or all health insurers.[2]

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[2] While the majority of states permit health insurers to pursue their members for subrogation when those members recover monies from third parties, "[a] small but solid minority of jurisdictions have rejected the insurance industry's attempt to expand subrogation beyond claims for property damage." Roger M. Baron, *Subrogation on Medical Expense Claims: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws*, 96 Dickinson L. Rev. 581, 584-85 (1992) (hereafter "Baron, *Subrogation on Medical Expense Claims*"). States prohibiting or sharply limiting subrogation by health insurers include Arizona, *Allstate Ins. Co. v. Druke*, 576 P.2d 489 (Ariz. 1978); Missouri, *Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418 (Mo. Ct. App. 1965); Nevada, *Maxwell v. Allstate Ins Co.*, 728 P.2d 812 (Nev. 1986); North Carolina, *Hampton Indus. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992); Pennsylvania, 75 Pa. Cons. Stat. § 1720; Oklahoma, *Aetna Cas. and Sur. Co. v. State Board for Property and Cas. Rates*, 637 P.2d 1251 (Okla. 1981); and Virginia, Va. (continued...)

Although petitioners and their *amici* never mention these laws, their arguments threaten to have a huge impact upon them. These parties have asked this Court to hold that subrogation by health insurers is an "equitable" cause of action within the meaning of § 1132(a)(3) because it is necessary to prevent the "unjust enrichment" of insureds who receive tort recoveries from third parties. *E.g.*, Brief for the Petitioners at 34, 36; Brief for the United States as *Amicus Curiae* Supporting Petitioners at 10, 14, 27; *Amici Curiae* Brief for the National Association of Subrogation Professionals, Inc. in Support of Petitioners at 2-3, Brief of *Amicus Curiae* American Association of Health Plans, the American Benefits Council, the Blue Cross Blue Shield Association, the Chamber of Commerce of the United States, and the Health Insurance Association of America ("The Health Insurance Industry Brief") at 3.

If this Court were to so hold, it is certain that health insurers will use this holding to attack anti-subrogation laws. Health plans have repeatedly raised the argument, for example, that actions implicating ERISA's enforcement provisions are preempted even if they fall within ERISA's Savings Clause. *See UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999) (declining to resolve insurer's argument that ERISA's Enforcement Clause overrides ERISA's Savings Clause and preempts a state law within the Savings Clause). While the Maryland HMO Subrogation Plaintiffs sharply disagree with this argument, if the Court construes Section 1132(a)(3) as creating a substantive rule of law in support of subrogation, that new rule will be used by health plans to cast a cloud over the many state laws limiting or

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[2] (...continued)
Code Ann. § 38.2-3405. A great many other states limit subrogation by providing that health insurers may not recover sums for subrogation from their insureds unless and until the insureds have been "made whole" by the third party tortfeasor.

prohibiting subrogation, and will thus potentially undermine the scope and force of ERISA's Savings Clause. Creating such a new substantive rule would thus jeopardize a number of state laws, and be directly contrary to this Court's direction that courts should be reluctant to find that ERISA preempts traditional bodies of state law.[3] Apparently unhappy with the laws of many states that limit or prohibit subrogation, the insurance industry is urging this Court to use this case as an opportunity to enunciate a new body of federal law that, the industry hopes, would sweep aside these state laws.

B. STATE ANTI-SUBROGATION STATUTES ARE SAVED FROM ERISA PREEMPTION BY ERISA'S SAVINGS CLAUSE.

While the scope of ERISA preemption under Section 1144(a) is quite broad, "[t]he saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(4), phrased with similar breadth, exempts from preemption 'any law of any state which regulates insurance.'" *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 360 (1999). "The effect of the [savings] clause is to save state laws governing the business of insurance from preemption that would otherwise occur by application of [the preemption clause]." *Stuart Circle Hosp. Corp. v. Prudential Health Mgt.*, 995 F.2d 500, 502 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993). This Court has explained that the Savings Clause "substantially qualifie[s]" ERISA's Preemption Clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985). Just two years ago, this Court again held that a body of state law falling within ERISA's

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[3] *See Pegram v. Hertrich*, 120 S. Ct. 2143, 2158 (2000) ("in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.")

Savings Clause is not preempted by ERISA. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999).[4]

This Court has made clear that, with respect to insured health plans, state anti-subrogation statutes fall within ERISA's broad

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[4] A wide variety of important state statutes and regulations have been spared from ERISA preemption under the Savings Clause, including state statutes mandating that insurance policies contain certain minimum benefits, *Metropolitan Life*, 471 U.S. 724; statutes prohibiting unreasonable discrimination in preferred provider organizations, *Stuart Circle*, 995 F.2d at 500; statutes requiring that substantially similar policies be issued by successor insurers, *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 300 (6th Cir. 1991); bad faith tort claims that are limited to the insurance industry, *Hill v. Blue Cross Blue Shield of Alabama*, 117 F. Supp. 2d 1209 (N.D. Ala. 2000); acts requiring that restricted pharmacy networks allow other pharmacies the right to provide drug benefits to insureds, *American Drug Stores, Inc. v. Harvard Pilgrim Health Care*, 973 F. Supp. 60 (D. Mass. 1997); laws forcing insurance companies to reimburse attorneys that procure workers compensation, *Levine, Benjamin, Tushman, Bratt, Jervis and Stein v. Paul Revere Life Ins. Co.*, 875 F. Supp. 404 (E.D. Mich. 1995); acts requiring the continuation of coverage for disability insurance policies, *Miller v. Northwestern National Life Ins. Co.*, 915 F.2d 1391, 1393 (9th Cir. 1990); laws providing for continued coverage by HMOs for a divorced spouse, *Cellilli v. Cellilli*, 939 F. Supp. 72 (D. Mass. 1996); notice-prejudice rules, *Dang v. UNUM Life Ins. Co. of America*, 175 F.3d 1186, 1192 (10th Cir. 1999); and torts for breach of an implied covenant of good faith and fair dealing, *Lewis v. Prudential U.S. Healthcare, Inc.*, 1999 U.S. Dist. LEXIS 18942 (N.D. Okla. October 20, 1999).

Savings Clause.[5] In *FMC*, 498 U.S. 52, this Court found that there was "no dispute" that a Pennsylvania anti-subrogation statute was within ERISA's Savings Clause. 498 U.S. at 60-61. *FMC* held that the anti-subrogation statute "directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain." *Id.* at 61 (citing *Metropolitan Life*, 471 U.S. at 740-41). This Court held that the anti-subrogation act did "not merely have an impact on the insurance industry; it [was] aimed at it." 498 U.S. at 61 (citation omitted.) This Court thus concluded that "[t]his returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the Savings Clause by virtue of the Deemer Clause, therefore, it is not preempted." 498 U.S. at 61.[6]

Other courts have followed this Court's direction that anti-subrogation acts are within the Savings Clause as they apply

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[5] ERISA's Deemer Clause, 29 U.S.C. § 6, 1144(b)(2)(B), represents an exception to the Savings Clause. As this Court stated in *UNUM*, self-funded health insurance plans are preempted from the Savings Clause. 526 U.S. at 367 n.2. Nonetheless, state laws that are protected from preemption with respect to insured plans are preempted with respect to self-funded plans.

[6] This Court nonetheless held that the Pennsylvania statute was preempted in *FMC* because, even though it fell within the Savings Clause, the defendant in *FMC* was self- funded. In this case, petitioners' plan is self-funded and, therefore, not within the scope of ERISA's Savings Clause. Nonetheless, as set forth above, if this Court were to embrace the suggestion of petitioners and their *amici* that it create a new federal rule of law endorsing subrogation by HMOs, the health insurance industry would surely attempt to use this new federal intrusion into the traditionally state law field of subrogation to launch an ERISA preemption attack upon those state laws limiting the industry's practices.

to insured plans. *See Medical Mutual of Ohio v. DeSoto*, 234 F.3d 298, 308 (6th Cir. 2000); *Hampton Indus. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992); *United Food & Comm. Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986) ; *Whitlinger v. Continental Cas. Co.*, 2001 WL 85836 at *6 (E.D. Va. Jan 22, 2001); *Donlan v. Greater Cleveland Reg'l Transit Auth.* 2000 U.S. Dist. LEXIS 6735 (N.D. Ohio, Mar. 31, 2000); *Blue Cross and Blue Shield of Alabama v. Fondren*, 966 F. Supp. 1093, 1097 (M.D. Ala. 1997); and *Blue Cross and Blue Shield of Alabama v. Lewis*, 754 F. Supp. 849 (N.D. Ala. 1991).

C. STATE REGULATIONS OF SUBROGATION ARE ENTIRELY CONSISTENT WITH ERISA'S SCHEME.

Some of petitioners' *amici* claim that ERISA's statutory structure and underlying purposes mandate that health insurers be permitted to collect subrogation. *E.g.* Health Insurance Industry Brief at 15-23. Those arguments are simply wrong. State anti-subrogation laws are entirely consistent with ERISA's scheme. ERISA principally operates to enforce the terms of benefit plans – to make sure that plan providers actually provide the benefits that are promised in the plan, whatever they may be. ERISA does not regulate the substantive terms of benefit plans, and it does not instruct benefit plans that they must include or not include any particular substantive terms. Accordingly, ERISA completely preempts state laws that mandate that employee benefit plans be administered in a particular way, laws that bind plan administrators to particular choices, or laws that provide alternate mechanisms for enforcing ERISA benefits. *See Coyne & Delaney Co. v. Selman*, 98 F.3d 1457, 1468 (4th Cir. 1996). *See also Cutting v. Jerome Foods, Inc.*, 820 F. Supp. 1146 (W.D. Wis. 1991), *aff'd*, 993 F.2d 1293 (6th Cir.), *cert. denied*, 510 U.S. 916 (1993) ("Rather than regulating the substance of benefits plans, ERISA regulates the administration, disclosure and reporting of

benefit plans to ensure that employees receive the benefits promised to them in writing.") Because state anti-subrogation statutes are regulations of the substantive provisions of insurance contracts, and not procedural regulations, they are entirely consistent with ERISA's scheme of preemption.

This Court should also embrace the well-established line of cases holding that ERISA embodies no substantive rule with respect to subrogation. *See Member Servs. Life Ins. Co. v. American Nat'l Bank and Trust Co. of Sapulpa*, 130 F.3d 950, 958 (10th Cir. 1997) ("ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content.") (quoting *Ryan v. Federal Express Corp.*, 78 F.3d 123, 127 (3d Cir. 1996)). This neutrality is in keeping with Congress's respect (reflected in ERISA's Savings Clause) for diverse state regulations of the business of insurance.

The Health Insurance Brief also asserts that a federal rule requiring subrogation by health insurers is necessary to fulfill Congress' intent that ERISA "assure uniformity and efficiency in plan administration." As this Court has recognized in the subrogation context, however, ERISA was designed to leave this issue to the states with respect to insured plans:

> By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

FMC Corp., 498 U.S. at 63.

II. AS MANY STATES HAVE RECOGNIZED, THERE ARE STRONG POLICY ARGUMENTS AGAINST PERMITTING HEALTH INSURERS TO SUBROGATE.

As noted above, petitioners and their *amici* urge this Court to reach the substantive conclusion that subrogation by health insurers is required to prevent the unjust enrichment of injured insurers. Petitioners and their *amici* thus ask this Court to express an adverse judgment as to the longstanding anti-subrogation laws of various states without even mentioning the existence of these laws.

In fact, the unjust enrichment argument put forward by petitioners and their *amici* gets the situation exactly backwards. As many commentators and state high courts have noted, subrogation by health insurers provides the *insurers* with a windfall – a second payment for medical care for which the insurers have already been paid (through premiums). As the leading scholar in this area has written:

> The successful collection of a subrogated claim results in a "windfall" to the insurer in the following sense: In paying the loss, the insurer simply pays an anticipated loss on a risk that has been actuarially distributed over a pool of similarly-situated insureds. The initial setting of the insurance premium for the transfer of the risk from the insured to the insurer encompasses the insured's pro-rata share of total estimated losses for the pool, as well as the insured's pro-rata share of the insurer's profit to be realized from the insurance undertaking. The prospect of a successful subrogation collection is not a factor in the insurer's rate determination. In fact, the conjectural and remote nature of subrogation militates against including it as a factor in premium rate setting. Thus, when an insurer pays out on an

> insured risk, any recovery that the insurer is able to obtain through subsequent subrogation is a "windfall" to the insurer.

Baron, *Subrogation on Medical Expense Claims*: The "Double Recovery" Myth and the Feasibility of Anti-Subrogation Laws, 96 Dickinson L. Rev. 581, 582 (1992) (footnotes omitted). The Nevada Supreme Court has expanded upon this point:

> [W]e conclude that it violates public policy to allow an insurer to collect a premium for certain coverage and then allow the insurer to subrogate its interest and deny the insured his benefits. Precluding the subrogation of the insurer does not result in a double recovery for the insured because the insured is merely receiving the benefits for which he has already paid. . . . Allowing subrogation deprives the insured of the coverage for which he had paid and results in a windfall recovery for the insurer.

Maxwell v. Allstate Ins. Co., 728 P.2d 812, 815 (Nev. 1986).

Petitioners and some of their *amici* attempt to avoid the windfall problem by arguing that, if insurers are not successful in pursuing their insureds for subrogation, this will result in the *insureds* receiving a windfall because they would recover money for expenses for which they had not paid. This assertion ignores the fact that plaintiffs *have* paid for this care when they paid their premiums. As Maryland's high court has held, "one of the purposes of" anti-subrogation statutes "is consumer protection." *Riemer v. Columbia Medical Plan*, 747 A.2d 677, 689 (Md. 2000). Noting that "[t]he entire [Maryland HMO Act] statutory scheme emphasizes that an HMO, by its definitions, provides health care services on a *prepaid* basis," *Id.* at 688 (emphasis in original) the court explained that insureds should not be required to pay subrogation because they have "already paid for services

rendered" through their premiums. 747 A.2d at 690. "The allegation that the insured will make a double recovery in the absence of medical payments subrogation is not persuasive for the insured has paid for that additional coverage." *Allstate Insurance Co. v. Reitler*, 628 P.2d 667, 670 (Mont. 1981). "Subrogation on non-property damage claims renders insurance coverage 'illusory' because the insured receives nothing for the separate premium paid to the insurer when a tort-feasor is liable for damages." Baron, *Subrogation on Medical Expense* Claims, at 588 (footnote omitted).

The claim of petitioners and their *amici* that subrogation by health insurers is necessary to prevent unjust enrichment of insureds stems from a premise – that insureds may not both recover funds from third parties and receive funds from insurers – that is flatly contrary to the longstanding doctrine of the collateral source rule. "The collateral source rule, widely recognized throughout the United States, generally provides that recoveries by a plaintiff from sources other than the defendant tortfeasor are not to be considered in determining the liability of the defendant or the amount of damages." Calvin R. Wright, *The Collateral Source Rule in Georgia: A New Method of Equal Protection Analysis Brings A Return to the Old Common Law Rule*, 8 Ga. St. U. L. Rev. 835, 835 (1992). This Court has firmly embraced this doctrine since 1854:

> The defense set up in the answer, that the libelants have received satisfaction from the insurers, cannot avail the respondent. The contract with the insurer is in the nature of a wager between third parties, with which the trespasser has no concern. The insurer does not stand in the relation of a joint trespasser, so that satisfaction accepted from him shall be a release of others. This is a doctrine well received at common law. . . .

The Propeller Monticello v. Mollison, 58 U.S. 152, 155 (1854). This doctrine is also widely accepted in nearly all of the states, despite the many and repeated efforts of the insurance industry to have it eliminated. In *Plank v. Summers,* 203 Md. 552 (1953), for example, Maryland's high court held "that where hospital and medical services are furnished gratuitously to the injured party, he can recover the value of those services from the tort-feasor." 203 Md. at 562. In support of this conclusion, the court noted:

> Here also it might well be considered that medical and hospital services supplied by the Government to these members of the United States Navy were part of the compensation to them for services rendered, and therefore that by their service in the Navy they had paid for these. If, by their services, the appellants paid for the medical and hospital expenses, certainly the value of these are proper items for the jury to consider in arriving at the amount of damages to be paid by the appellee.

Id. In the *Riemer* case, Maryland's high court recognized that the anti-subrogation provisions of Maryland's HMO Act were consistent with that state's jurisprudence recognizing the collateral source rule. 747 A.2d at 690.

The collateral source rule is so well established in the states that on a number of occasions state high courts have struck down as unconstitutional legislation that attempted to override the rule. *See, e.g., O'Bryan v. Hedgespeth*, 892 S.W.2d 571 (Ky. 1995); *Carson v. Mauer*, 424 A.2d 825 (N.H. 1980); *Denton v. Con-Way Southern Express, Inc.*, 402 S.E.2d 269 (Ga. 1991); *Farley v. Engleken*, 740 P.2d 1058 (Kan. 1987). The collateral source rule is thus directly analogous to state anti-subrogation laws. In each instance, the insured has "paid" for their medical care by paying their premiums to the insurer, just as the *Plank* plaintiffs had "paid" for their medical care by working for the Navy.

The Health Insurance Industry Brief paternalistically asserts that the health insurers are taking subrogation monies from their insureds for the insureds own good, and that injured insureds greatly benefit from having their money taken from them this way. Health Insurance Brief at 6. These self-serving pronouncements are based on the patently false premise that wherever insureds make more money, their insureds will benefit equally. In fact, subrogation in the health insurance context is affirmatively harmful to insureds. Because it is impossible to quantify the true loss to the plaintiff from a personal injury, subrogation in that setting will often leave the plaintiff without full compensation:

> Subrogation rights are commonly allowed when the insured sustains a *fixed* financial loss. . . . In personal insurance contracts, however, the exact loss is never totally capable of ascertainment, and therefore the same reasons militating against double recovery do not obtain.

Aetna Cas. and Sum. Co. v. State Bd. for Property and Cas. Rates, 637 P.2d 1251, 1255 (Okl. 1981) (emphasis in original; footnote omitted). *See also Allstate Ins. Co. v. Druke,* 576 P.2d 489, 492 (Ariz. 1978):

> The rule against assignability of personal injury claims is based in sound public policy. A victim's medical expense insurance coverage does not provide full indemnity. While it may indemnify him completely for his medical expenses . . . , such expenses may constitute only a portion of his total loss. In addition to other "out-of-pocket" losses, . . . an accident victim often suffers non-economic losses such as physical pain and mental anguish which are often not monetarily indemnifiable and never insurable. Under the repayment provision in the instant case, the insurance company obtains full reimbursement for its medical expense

payments regardless of whether the victim's tort recovery fully covers his actual damages.

See also Reitler, 628 P.2d at 670 ("the injured person often must compromise the personal injury claim, either because of liability problems or because of limited coverage carried by the tort-feasor. Yet under subrogation the plaintiff's insurer makes a full recovery."); *Maxwell*, 728 P.2d at 815 (same); Baron, *Subrogation on Medical Expense Claims*, at 589.

The Health Insurance Industry Brief also claims that permitting subrogation will reduce health insurance premiums. Brief at 11-12, 16-17. There is no empirical support for this proposition, however. The health insurance industry, which alone has possession of the tapestry of multi-state premiums, makes no effort to argue (much less prove) in its brief that health insurance premiums in the numerous states that forbid subrogation are higher than premiums in the states that permit subrogation. Is there any serious claim that health insurance premiums are far higher in Virginia than in the District of Columbia, for example? The Health Insurance Industry Brief relies upon the patent fiction that each additional dollar of revenue goes not to higher profits or to higher executive compensation, but instead to reduced premiums.

In fact, a number of state legislators and judges have found that claim to be false. The Arizona Supreme Court, for example, has stated:

> In terms of public policy, the only justification for allowing an insurance company to recoup the benefits it contracted to pay out in exchange for the receipt of premium payments which are presumably actuarially adequate would be the lowering of premium rates as a result of such recoupment. This is generally not the case:

> "Subrogation is a windfall to the insurer. It plays no part in the rate schedules (or only a minor one), and no reduction is made in insuring interests . . . where the subrogation right will obviously be worth something."

Allstate Ins. Co. v. Druke, 576 P.2d 489, 492 (Ariz. 1978) (citations omitted). *See also Travelers Indem. Co. v. Chumbley*, 394 S.W.2d 418, 425 (Mo. Ct. App. 1965) ("'[C]onditioning' medical payments coverage [upon subrogation] does not, in fact, work a perceptible reduction in the premium charged for such coverage.")

The Health Insurance Industry Brief correctly states that doctrine of subrogation generally has a long history in the law, Brief at 7, but incorrectly suggests that subrogation by *health insurers* in personal injury cases has an equally long history. In fact, subrogation by health insurers is a practice of relatively recent origin, and the historic body of law permitting subrogation stems from property damage cases, and not from personal injury cases. "The doctrine of subrogation has its genesis in *property* insurance, an area of the law of subrogation that has remained fairly stable." Baron, *Subrogation on Medical Expense Claims*, at 583 (emphasis in original). *See also* Keith E. Edeus, *Subrogation of Personal Injury Claims: Toward Ending an Inequitable Practice*, 17 N. Ill. U. Rev. 509, 512 (1997) ("Under the common law, the doctrine was held not to allow subrogation of personal injury claims, so most jurisdictions initially refused to so extend the doctrine.") It was not until the 1960's that insurers began to seek subrogation in health insurance cases. *Id.* To strike down state anti-subrogation laws would be a sweeping act, and the Health Insurance Industry's suggestion that all its members have been subrogating everywhere for a long time is simply not accurate.

CONCLUSION

This case involves the correct interpretation of 29 U.S.C. § 1132(a)(3). Petitioners and their *amici* have, however, asked this Court to go beyond the question presented and declare that federal law under ERISA contradicts (and, they hope, therefore overrides) a host of state laws restricting subrogation by health insurers.

This Court should reject that request. Nothing in ERISA or any other federal law requires subrogation by health insurers, or provides that such subrogation is necessary to avoid the unjust enrichment of the injured insureds. The question of who is unjustly enriched when health plans do or do not subrogate is one on which many states disagree, and nothing in federal law imposes an answer one way or the other. The ability of states to restrict or prohibit subrogation by health insurers is protected by ERISA's Savings Clause, and very strong policy arguments support those states who choose to enact such laws. There is no justification for this Court to override these state laws, and this Court should reject the covert suggestions of petitioners and their *amici* that it should do so.

Respectfully submitted,

F. Paul Bland, Jr. (*Counsel of Record)*
Leslie Brueckner
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
1717 Massachusetts Avenue, N.W.
Suite 800
Washington, D.C. 20036
(202) 797-8600

Arthur H. Bryant
TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C.
One Kaiser Plaza
Suite 275
Oakland, CA 94612
(510) 622-8150

Attorneys for *Amici Curiae*
Maryland HMO Subrogation Plaintiffs

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